A Culture of Safety

BY **VJOHNSON** – MARCH 27, 2014

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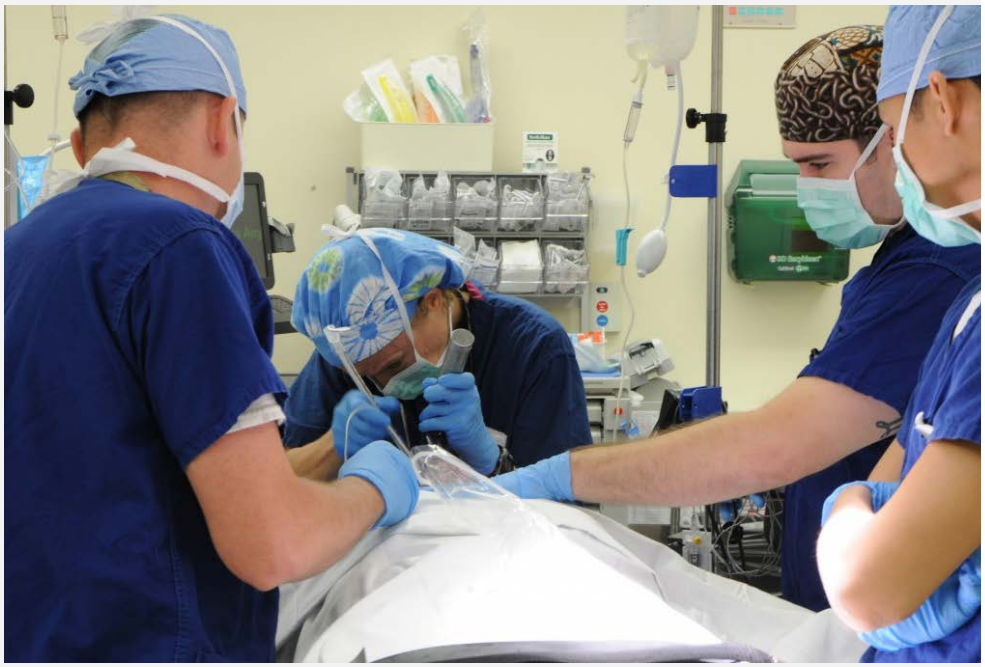
By Paul Ross

Healing the sick, preventing illness and mending the broken is the main goal of any medical community. In military medicine the added requirement of readiness is critical and is the main priority. Navy Medicine runs military treatment facilities to keep a force of medical personnel ready to deploy in support of our warfighters when needed. But none of these goals are met if the patient's safety is not paramount.

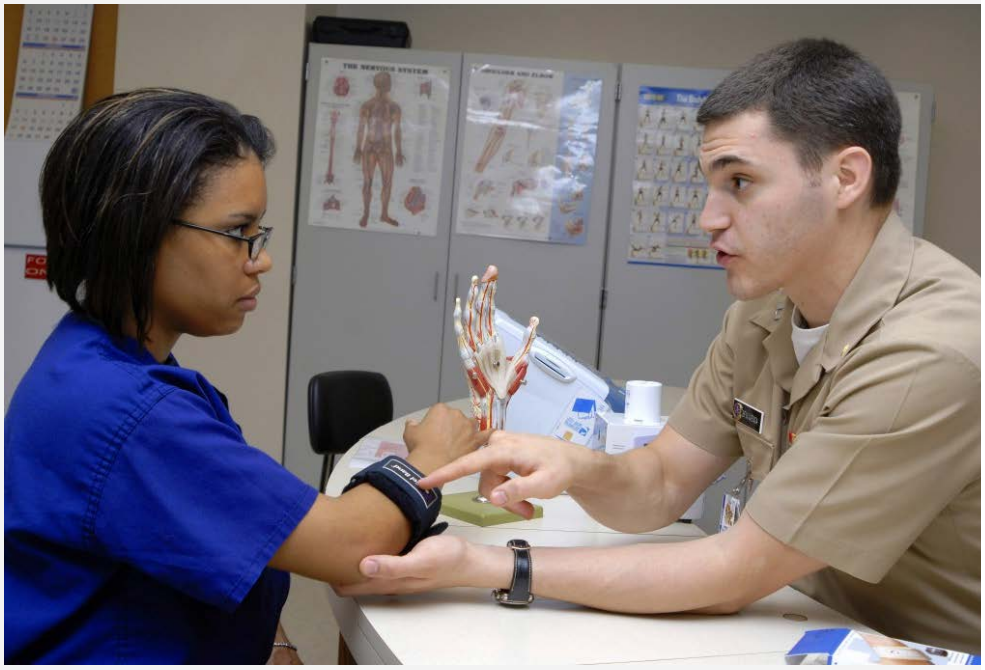


A patient undergoes a surgical procedure at Naval Hospital Pensacola. The hospital was recently named a 2012 Top Performer on Key Quality Measures by The Joint Commission, the leading accreditor of health care organizations in the United States. The hospital was recognized for its application of best practices for surgical care and treatment of venous thromboembolism (VTE), a blood clot that forms within a vein. (Photo by Mass Communication Specialis First Class James Stenberg)

Navy Medicine has created a culture of safety that ensures mistakes are mitigated, processes are improved, and things are being done the best way possible.

"Patient safety is a multi-dimensional effort," said Carmen Birk, U.S. Navy Bureau of Medicine and Surgery (BUMED) risk manager. "It involves a number of key principles that have become a

part of our culture instead of just bullet points on a check list. By making these principles the way-of-life across Navy Medicine we are delivering high-quality and safe patient care."



Lt. Mario Bencivenga, and occupational therapist at Naval Hospital Jacksonville, applies a counterforce brace to the forearm c Lt. Cmdr. Angela Powell during a check-up. The hospital's state-of-the-art facility is poised to become a vital regional warrior care center. Equipment includes an aquatic treadmill for patients to build strength and fully equipped living quarters for patient to regain the skills of daily living. (Photo by Jacob Sippel)

These principles reach far and wide across the spectrum of care.

"Some principles include something as simple as the steps we take in identifying a patient and making sure a procedure is being performed on or medication is being delivered to the correct person," said Birk. "It involves how our providers communicate with each other and with our patients. It also includes fixing mistakes when they do occur and always looking for ways to do things better."

An organization that guides these principles is the Joint Commission, which is an independent, not-for-profit organization that accredits and certifies, through onsite surveys, more than 20,000 health care organizations and programs in the United States, including naval hospitals.

"The Joint Commission accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting designated performance standards," Birk said.

According to the Joint Commission's website, www.jointcommission.org, the organization's mission is to continuously improve health care for the public, in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value.

"The Joint Commission's standards focus on patient safety and quality of care and are updated regularly to reflect advances in the health care community," said Birk.

The hospital accreditation standards number more than 250, and address everything from patient rights and education, infection control, medication management and preventing medical errors, to how the hospital verifies that its doctors, nurses, and other staff are qualified and competent. The Joint Commission also evaluates how it prepares for emergencies and how it collects data on its performance and uses that data to improve itself. Accreditation occurs every 18-36 months when an onsite survey is completed by The Joint Commission.

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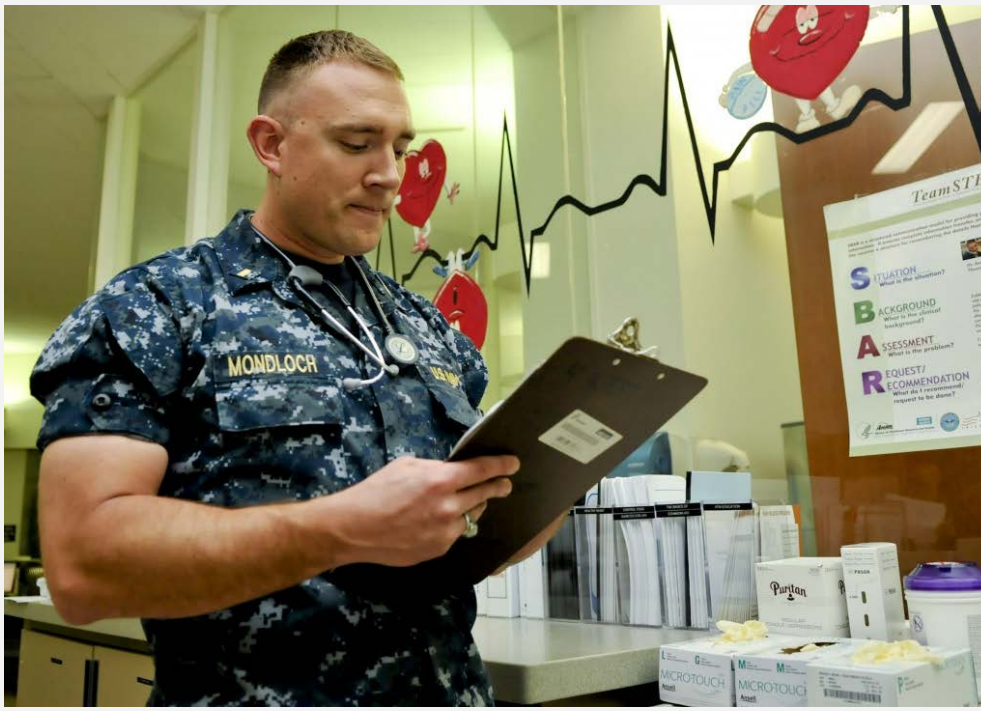
Along with The Joint Commission standards, the Department of Defense (DoD) has implemented its own programs to constantly improve patient safety.



Ensign Joshua Mondloch, a nurse assigned to Naval Medical Center San Diego, takes notes in the cardiology in-patient ward More than 1,000 active duty and civilian nurses provide patient care throughout the medical center.
(Photo by Mass Communication Specialist Second Class John O'Neill Herrera)

TeamSTEPPS®, or Team Strategies and Tools to Enhance Performance and Patient Safety, is a patient safety initiative developed by several health care organizations, including the DoD Patient Safety Program (PSP) and the Department of Health and Human Services' Agency for Healthcare Research and Quality (AHRQ).

"A DoD program, called 'TeamSTEPPS®, gives staff the tools to effectively communicate in different situations," Birk said. "Some of those tools may include 'huddles' in the morning where caregivers get together before a shift and discuss the plan for the day, patients' needs (like tests), etc. Patients are also included in the process, where the key care givers let the patient know that 'one member of our team is going to check on you every hour.'"

The program is designed to improve the quality, safety, and efficiency of health care delivered to patients by enhancing the level of communication and mutual support between team members. This approach allows everyone to be on the same page in caring for the patient – including the patients themselves.

The Navy Surgeon General, Vice Adm. Matthew Nathan, is keeping patient safety at the forefront by releasing his Culture of Safety initiative in January 2014.

"The thing we're doing this year is addressing culture of safety survey findings that all of Military Health System (MHS) took in 2011," said Christine Winslow, U.S. Navy Bureau of Medicine and Surgery senior analyst. "The survey showed that we could improve the ability to speak up, the ability to challenge staff members."

Communication is a key issue across the health care field.

"This is a continuing issue for the health care industry in general," Winslow said. "Vice Adm. Nathan has made this a personal goal to try to understand how we can improve communication in Navy Medicine. He wants people to be able to know what good safety

practices are and to speak up when staff have concerns about how a procedure is being done. It's a compelling initiative. Leadership is engaged and committed to keeping their fingers on the pulse of this issue."

The 2011 MHS survey findings led to two specific initiatives.

"The first was participation in the Partnership for Patients Initiative, which was a MHS-wide initiative and based on the Centers for Medicare and Medicaid program that focused on decreasing hospital-acquired conditions and adverse harm events at facilities and also preventable readmissions," said Winslow. "We are at the end of the year-long implementation period and are going into sustainment."

Through the Partnership for Patients Initiative, Navy Medicine focused on nine hospital-acquired conditions and reduction of the number of preventable readmissions – meaning that if a patient is treated and can go home, they shouldn't have to return to the hospital for something that can be prevented.

"We looked at our readmissions within a 30 days period," Winslow said. "MHS adopted the Centers for Medicare & Medicaid Services targets. The initiative involved standardizing some of our guidelines and procedures across the MHS so that care was transparent and consistently high in value and quality. We have a commitment to that and have shown positive trends in the readiness of patients."

The second initiative involves Navy Medicine looking at communication efforts among staff in various situations. In order for a system to be able to improve processes there must be a system to report mistakes or opportunities to do things better.

"What can be reported are good catches – something that almost happened, such as 'I almost picked up the wrong drug because it looked just like the other one,'" Birk said. "Or they can report things that happened to a patient, but where there was no harm to the patient. Or they can report things that did happen to the patient and they report what happened as a result of that. They can report anonymously or they can put their name on it. That's all part of our quality assurance process. The whole event is looked at and it may generate more reviews that must be done, to see if we have a process that needs improvement or a system failure that we need to address or change."

Doing regular root cause analyses (RCA) is another tool that allows Navy Medicine to determine what went wrong in order to come up with a solution. A RCA allows providers to determine what went wrong in order to come up with a solution.

"The root cause analysis looks at the processes," Birk said. "What broke down here? Did we do the universal checklist at the wrong time? Did we leave out looking at the x-ray? Do we have to change the timing for when we turn the patient in terms of when we decide to prep the site?"

A specific change that took place over the past decade that improved patient safety was a direct result of RCA.

"We had a situation several years ago where sponges were unintentionally left behind after some surgical procedures," Winslow said. "Sometimes you don't see the sponge because it looks like tissue and we weren't counting sponges during these procedures. We had a couple of incidents and through the root cause analysis process, one of our facilities came up with an innovative idea to use bigger, numbered sponges. They are larger sponges with a tail and a strip in them so they can be identified through an x-ray if you think one has been left behind. We now have a process to count sponges to make sure what is opened is retrieved at the end

of the procedure."

After the implementation of this process Navy Medicine's incidents were significantly reduced.

Along with RCAs, peer review is a cornerstone to maintaining a culture of safety. It allows the care and credentialing of a specific provider to be reviewed to ensure the patient is receiving the care they deserve.

These types of reviews are essential in ensuring Navy Medicine physicians are providing the highest quality care to their patients.

"Providers have privileges at one command and transfer to another," Malara said. "They've been exercising these privileges for the past three years. The new hospital has an evaluation sheet that's done on each incoming provider to document performance review that they have to sign off on. The command does the focused review to make sure the provider knows how to do what they say they did at the other command. That review can be short or long depending upon what they find. If the provider only saw children once a month at the previous command but at this command they'll see children every week, they will have another provider do a review to ensure the new physician meets all requirements. Once that is completed then the ongoing professional practice evaluation is instituted."

But despite the countless number of improvements across Navy Medicine, the people providing care are always looking for ways to get better.

"This highlights the continuous improvement nature of a good quality and safety culture," Winslow said. "You should never rest on your laurels."

Because of the processes in place, Navy Medicine's culture of safety is stronger than it's ever been.

"Our patients are safer today because we have so many more checks and balances in place than 20 and 30 years ago," Birk said.

About vjohnson